DOCUMENT RESUME

ED 430 184 CG 029 273

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TITLE Burnout and Leadership in Community Mental Health Systems.
PUB DATE 1999-04-00
NOTE 21p.; Paper presented at the Annual Conference of the American Educational Research Association (Montreal, Quebec, Canada, April 19-23, 1999).
PUB TYPE Reports - Research (143) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Behavior; *Burnout; *Community Services; *Counselors; *Leadership; *Mental Health Clinics; Models; Prevention; *Supervision
IDENTIFIERS Leadership Practices Inventory; Maslach Burnout Inventory

ABSTRACT

This study investigated the nature of professional burnout, specifically whether aspects of burnout in clinical staff in community mental health agencies were systematically related to aspects of leadership behavior and quality of supervision of clinical supervisors. Burnout was measured by the Maslach Burnout Inventory, leadership behavior in clinical supervisors was measured by the Leadership Practices Inventory, and clinical supervision was measured by a scale constructed by the authors. One hundred and fifty-one respondents from five community mental health systems participated in the study. Significant though moderate relationships were found between the measures, and the implications for an organizational model of burnout, as well as prevention of burnout in mental health professionals, are discussed. An appendix provides the Clinical Supervisor Rating Scale and five tables depicting results of the study. (Contains 23 references.) (Author/MKA)

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ED 430 184

Running Head: BURNOUT AND LEADERSHIP

Burnout and Leadership in Community Mental Health Systems

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To appear in *Administration & Policy in Mental Health*, autumn 1999.
Webster, L. & Hackett, R. K. Burnout and Leadership In Community Mental Health Systems. Paper presented at the annual American Educational Research Association, Montreal, Canada, Spring 1999.

CG029273

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Abstract

This study investigated the nature of professional burnout, specifically whether aspects of burnout in clinical staff in community mental health agencies were systematically related to aspects of leadership behavior and quality of supervision of clinical supervisors. Burnout was measured by the Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996), leadership behavior in clinical supervisors was measured by the Leadership Practices Inventory (Posner & Kouzes, 1997), and clinical supervision was measured by a scale constructed by the authors. One hundred and fifty-one respondents from five community mental health systems participated in the study. Significant, though moderate relationships were found between the measures, and the implications for an organizational model of burnout, as well as prevention of burnout in mental health professionals are discussed.

Burnout and Leadership in Community Mental Health Systems

Research shows that mental health professionals in Community Mental Health systems often pay a heavy psychological price for the intense emotional interactions the job demands, frequently resulting in what is known as burnout (Leiter & Maslach, 1997; Cherniss, 1995). Burnout has been defined in the literature as a syndrome of physical and emotional exhaustion, involving the development of a negative self-concept, negative job attitudes, and the loss of concern and feelings for clients (Maslach & Jackson, 1986). Three aspects of burnout have been identified: feelings of being emotionally exhausted and overextended by the work; feelings of depersonalization which result in negative, cynical attitudes towards one's clients; and diminished personal accomplishment which reflects a sense of lowered competence and a lack of successful achievement in work with clients. Burnout has been reliably and validly measured by the Maslach Burnout Inventory (Maslach & Jackson, 1986; Maslach, Jackson, & Leiter,1996) which has three subscales: emotional exhaustion, depersonalization, and diminished personal accomplishment. Research indicates that it is the *depersonalization* component which is specific to human service workers, for whom the interpersonal relationship with clients is central (Golembiewski & Munzenrider, 1988). Depersonalization is an alarming attitude for professionals whose purpose is to empower others through the medium of the therapeutic relationship which necessitates compassion, empathy, and respect. Furthermore, research suggests that burnout does indeed lead to a deterioration in the quality of care or service provided by staff, and is a factor in turnover, absenteeism, and low morale (Leiter, Harvie, & Frizzell, 1997; Pines & Kafry, 1978; Pines & Maslach, 1978).

Past research has focused on individual characteristics of the clients and workers as the source of stress; however, recent research has investigated the larger systemic issues which may have an equally large impact on the mental health status of the professionals and their relationships with their clients. Cherniss (1980) focuses on five inconsistencies in the

expectations of the role of a service provider and the realities of the organizational systems, which lead to burnout if not adequately resolved: competence and utilization of skills, autonomy and control, difficulties with clients, boredom and routine, and lack of collegiality. Leiter (1991) argues that Cherniss' perspective implies that research and interventions should be based on *organizational* change, as opposed to focusing on the individual employee or client as the source of the problem. Leiter (1993, 1991) has concentrated his efforts on developing a process model to determine the distinct relationships of each aspect of burnout with environmental conditions, and his research, in combination with Maslach's (Leiter & Maslach, 1997), has consistently shown that organizational problems were associated with burnout more than were problems encountered in providing service. The professionals in Cherniss' longitudinal study (1993) complained about excessive workloads, lack of administrative support, and bureaucratic constraints; however, the underlying issue seemed to be that they could not feel successful and competen. This was not because they lacked the skill and ability, but because systemic factors prevented them from using those skills in a way that would achieve intended outcomes. Cherniss (1995) found that professional autonomy and support emerged as one of the most important requirements for fulfillment at work. Professional autonomy and support strongly mitigated against the experience of burnout, and these factors were also important in the recovery from burnout.

Supervision is a critical component in human services, especially in mental health contexts, and since supervisors control instrumental aspects of the work environment they are seen as critical contributors to whether emotional exhaustion occurs or not. Mental health clinicians engage in intense emotional interactions with their clients, with the objective of solving problems, frequently with inadequate resources. In order to combat the inevitable emotional fatigue associated with this kind of work, clinicians need supervisors who promote positive relationships amongst staff and administration, who help staff focus on client strengths, and who model appropriate behavior and values to staff (Evered &

Selman, 1989). Paralleling the therapeutic relationship, supervisors also need to focus on staff strengths. Insufficient supervisor support and conflict amongst colleagues has been shown to contribute directly to emotional exhaustion (Leiter, Gaudet, & Millett, 1986; Beehr, 1985), and there is evidence that leaders can affect the attitudinal climate of the work setting (Glisson, 1989). In a study which involved nurses, Leiter and Maslach (1988) found that pleasant contact with supervisors was negatively related to Depersonalization, while unpleasant supervisor contact was positively related to Emotional Exhaustion. These interrelationships have not yet been investigated for mental health clinicians and their clinical supervisors. Professionals who are providing meaningful service to their clients and who have a sense of autonomy and support from their immediate supervisor may feel sufficiently energized that they do not experience emotional exhaustion, or at least experience it to a lesser degree. An improved understanding of these relationships could provide interventions that are directly applicable to the supervisor-mental health worker relationship. The purpose of this study, therefore, was to investigate whether specific aspects of leadership behavior among supervisory staff were systematically related to specific aspects of burnout among clinical staff in community mental health agencies. The Maslach Burnout Inventory (Maslach & Jackson, 1986; Maslach, Jackson, & Leiter, 1996) was utilized for the measurement of burnout, and the Leadership Practices Inventory (Pozner & Kouzes, 1997) was utilized for the measurement of leadership behavior in clinical supervisors. The LPI was developed as an empirical measure of a conceptual leadership framework which was developed from case studies of exemplary leaders at all levels in a variety of settings. The LPI has consistently demonstrated excellent reliabilities (see Posner & Kouzes, 1993), and measures individual leadership actions and behaviors along several dimensions: challenging the process, inspiring a shared vision, enabling others to act, modeling the way, and encouraging the heart.

Methods

Subjects.

The current study investigated the relationship between specific aspects of burnout, as measured by the Maslach Burnout Inventory (1996) and clinical supervisor leadership as measured by the Leadership Practices Inventory (1997), amongst mental health clinicians employed in Community Mental Health agencies in five counties in Northern California. The sample consists of 151 volunteer respondents of whom 33% are men and 67% are women. They range in age from 23 to 73 years with the average being 44 (SD= 10). The ethnic distribution of the sample is White/Caucasian (76%) Latino/Hispanic/Mexican American (11%); Asian/Asian American (5%); Black/African American (4%); Native American/ American Indian (3%); and 1 percent "Other."

The respondents hold a variety of licenses: LCSW (27%); MFCC (25%); Psychologist (10%); Nursing (4%); and, Medical Doctor (2%). Nineteen percent of the respondents are "license-eligible," and the remaining 14% hold no license and are not currently eligible. Respondents who hold licenses have done so for 11 years, on average, with the median being 10 years. Only those respondents who had at least six months experience working in the county system were included in the analysis. It was deemed that less than six months of employment would be an insufficient period of time for burnout to develop as a result of the current system.

Procedure.

County mental health clinicians, employed by those counties whose administration agreed to participate in the study, were mailed a request to participate in the study, along with the Maslach Burnout Inventory, the Leadership Practices Inventory, and a demographic information sheet which contained a pilot measure of a Clinical Supervisor Rating Scale (CSRS). Those individuals who wished to participate then filled out the forms

and returned them in the supplied self-addressed, stamped envelopes. Responses were coded according to county, but individual's identities were not known.

Results

The univariate descriptive statistics for each variable are first presented as a way of both characterizing our sample and exploring whether, for any measure, the variability appears sufficiently restricted so as to underestimate the magnitude of its relationship with other variables (see Table 1).

On all five of the factors derived from the Leadership Practices Inventory, the responses nearly spanned the entire range of scores possible (6-60). It is evident, however, that the distributions of scores on the Leadership Practices Inventory scales are negatively skewed (see Table 2). This is particularly pronounced for the "Enabling Others to Act" scale where 80% of the respondents' scores suggest that the positive leadership practices represented by these items are at least "fairly often" (or more frequently) occurring while only 12% of the scores suggest such practices to be occurring "once in a while" (or less frequently).

The version of the LPI used for this study was a new version, and response options extended from 1 to 10 as opposed to 1 to 5 in the previous version. Normative data was unavailable for the 1997 version; however, data from the 1993 version does indicate that the data tend to be negatively skewed.

Based on cut points established by the scale's authors, respondents' level of burnout is classified as being low, moderate, or high. The results of this study indicated that, in comparison to mental health workers on whom the measure was normed, a very high proportion of individuals in this study are feeling emotionally exhausted; however, the overwhelming majority of them are feeling a strong sense of personal accomplishment (see Table 3). The Depersonalization scale results in this study span the levels fairly evenly with almost 1/3 in the low, 1/3 in the moderate, and 1/3 in the high levels of burnout.

The Clinical Supervisor Rating Scale consists of 7 positively worded items (see Appendix). By considering that scores of 0-2 express disagreement and 3-5 express agreement, it is possible to gauge the variability of the sample and sense how satisfied respondents tend to be with their supervisors. In general, 74% of the supervisors were evaluated positively (see Table 4).

While several of the distributions are negatively skewed, there appears to be sufficient variability to detect at least modest correlations between measures. Personal Accomplishment is markedly skewed, potentially restricting the variability with the result of underestimating relationships between this measure of burnout and the LPI and Clinical Supervisor Rating Scale (CSRS). Overall, however, restriction in range does not appear to significantly threaten the accuracy of estimates of relationships between leadership, supervision, and burnout. The Cronbach alpha reliabilities for the Leadership Practices Inventory scales ranged between .92 and .96; those for the Maslach Burnout Inventory scales ranged between .71 and .89; and the reliability of the Clinical Supervisor Rating Scale (CSRS) was .95. Hence, severe attenuation of the correlations due to unreliability of measures was not suspected.

Composite scores for the five scales of the Leadership Practices Inventory and the composite score of the CSRS were correlated with the three indicators of burnout: Personal Accomplishment; Emotional Exhaustion; and Depersonalization. Eleven of the eighteen correlations were statistically significant at the .01 level of significance. Note that one-tail tests were performed because personal accomplishment theoretically is expected to be positively correlated with quality leadership and supervision practices; also, emotional exhaustion and depersonalization are expected to be negatively correlated with quality leadership and supervision practices.

None of the leadership scales nor the supervision scale was found to correlate with Personal Accomplishment. However, all of the leadership scales were found to be

inversely related to Emotional Exhaustion. In addition, Depersonalization was inversely related to the supervision scale and four of the five leadership scales (see Table 5).

A secondary interest of this study was to investigate differences in ratings of burnout and leadership between groupings of therapists who differ on background (demographic) variables. This was accomplished utilizing one-way ANOVA techniques. Significant differences between clinicians of varying ethnic backgrounds were found on all the dimensions of the LPI: Encouraging the Heart, $F(2,135) = 2.61$, $MSE = 229.61$, $p = .07$; Enabling Others to Act, $F(2,141) = 3.44$, $MSE = 157.00$, $p = .03$; Inspiring a Shared Vision, $F(2,137) = 3.04$, $MSE = 169.48$, $p = .05$; Challenging the Process, $F(2,135) = 5.07$, $MSE = 186.05$, $p = .01$; Modeling the Way, $F(2,133) = 5.08$, $MSE = 170.04$, $p = .01$. A significant difference was also found between ethnic groups on the CSRS, $F(2,140) = 5.18$, $MSE = 77.52$, $p = .01$. On the average, an ethnic minority grouping consisting of African Americans, Asian Americans, Native Americans, and Others rated their supervisors lower on the LPI and on the CSRS, compared to groupings of Caucasians and Hispanics. Ethnic differences also emerged on the MBI for Personal Accomplishment, $F(2,142) = 3.24$, $MSE = 28.97$, $p = .04$; and Depersonalization, $F(2,142) = 2.62$, $MSE = 24.91$, $p = .07$. The same ethnic minority grouping rated themselves as experiencing less Personal Accomplishment and more Depersonalization than the groupings of Caucasians and Hispanics.

Significant differences were found for two dimensions of the LPI according to the primary assignment of the clinician. Those clinicians primarily working with children rated their supervisors higher in regards to Encouraging the Heart $F(4,109)= 2.61$, $MSE = 215.20$, $p = .04$; and Enabling Others to Act, $F(4,114) = 3.50$, $MSE = 137.22$, $p = .01$.

Finally, significant differences emerged on two of the MBI scales according to licensed versus licensed-eligible status of the clinician. Individuals who are license-eligible (post-Master's degree, but gaining experience prior to the license) rated themselves lower

on Personal Accomplishment, $F(4,127) = 3.02, 25.79, p = .02$, and higher on Depersonalization, $F(4,127) = 4.55$, $MSE = 22.81$, $p = .01$.

Conclusion

The results of this study do indicate a significant, although modest relationship between the LPI and Emotional Exhaustion, and between the majority of the LPI scales, CSRS, and Depersonalization. (It is possible that restriction of range in the distribution in Personal Accomplishment scores results in an underestimating of the true relationship between it and the leadership and supervisor practices.) In spite of the fact that the correlations are small, that they do exist and are significant has important implications for applied models of burnout.

The results suggest that clinical supervisors can provide leadership which may contribute to the development of a positive working climate. This, in turn, may reduce an employee's sense of emotional exhaustion and depersonalization. More specifically, the qualities of positive leadership include: seeking out and accepting challenging opportunities to improve the organization and learn from mistakes; enlisting and engaging others in working together toward a common goal; fostering collaboration and empowerment; behaving in ways which are consistent with their stated goals; and by recognizing both individual and team accomplishments.

Of interest to both trainers and practitioners alike are the differences found amongst the differing ethnic groupings of this study. The results suggest that leadership style preferences in human service settings may be culturally determined. In a study which surveyed job satisfaction amongst 2198 human service workers in six county welfare departments, McNeely (1992) found some interesting differences amongst different ethnic and racial groups. He argued that for African Americans, some race-linked job satisfaction differences might be related to the racial status of those in chief executive roles. There is also some evidence that African Americans experience more stress in organizations which are run by European Americans (Bush, 1977). McNeely (1992) further argued that for

Asian Americans, a major issue in job satisfaction was whether or not they perceived that superiors were friendly towards subordinates. The job satisfaction for Hispanics, on the other hand, was found to be most related to the degree to which the occupation was held in high esteem. In the present study, Hispanics showed no difference between Caucasians on their ratings of supervisor's leadership; while the grouping which contained African Americans, Asian Americans, Native Americans, and Others rated their supervisor's significantly lower. This same ethnic minority grouping rated themselves as experiencing less Personal Accomplishment and more Depersonalization than the groupings of Caucasians and Hispanics. The implication is that administrators need to be sensitive to leadership styles when providing clinical supervision. A leadership style that works well with one or two racial populations may not be as efficient and, in fact, may have a detrimental impact on certain ethnic populations resulting in their increased experience of Depersonalization and decreased sense of Personal Accomplishment. Supervisors need to become aware of these differences and modify their approach accordingly so as to empower these clinicians who are essential resources for the community. In the same way that clinicians are trained to be sensitive to cultural issues with clients, trainers and educators of clinicians also need to increase student awareness of the impact of cultural background and ethnicity on the supervisor-supervisee relationship. These results also accentuate the importance of the hiring and retention of ethnic minorities in supervisorial and management positions.

The results of this study also have implications for those clinicians working with more chronic adult populations. Clinicians providing service to adults in the form of outpatient psychotherapy and case management rated their supervisors lower than clinician's whose primary assignment was working with children on two dimensions of the LPI: Encouraging the Heart and Enabling Other to Act. It may thus be more difficult for the supervisors in adult units to foster collaboration and recognize the contributions and accomplishments of the clinicians serving this population. It suggests that this is an

organizational issue which needs to be addressed from a systemic perspective. For example, if there are too few accomplishments to be celebrated and too few opportunities for collaboration amongst staff who work with chronically mentally ill adults, administration should investigate means to recognize the contributions that the clinicians make on a daily basis, and should increase collaboration between units, contract agencies, and the community.

Lastly, trainers and educators need to focus on the adequate preparation of their students for the first few years of their post-Master's degree experiences. The results of this study indicate that these individuals are at a higher risk for experiencing symptoms of burnout, and it is arguable that this is due to a lack of experience and preparedness for the rigors and realities of the work. Most university professional programs do a good job of preparing clinicians for the technical aspects of their future positions (e.g., counseling skills), but a poorer job of preparing their graduate students in how to negotiate systems successfully. This cannot be accomplished in a simple didactic course; theory and methods must be integrated with actual exposure to various mental health systems. Students must be placed in the field early on in their training, and given assignments which necessitate that they grapple with the issue of how to carve out a role of a mental health professional in a complex system. For example, students could be assigned the task of designing and implementing a systemic mental health intervention in which they are responsible for negotiating their role and for garnering support for the project within the existing administrative structure. Managers and administrators of mental health systems also share some responsibility in providing and structuring mentoring relationships for their novice employees in order to avoid overloading and overwhelming them.

Students must also be trained how to become effective leaders and supervisors in mental health systems. Many of those in "middle" management in mental health systems are former clinicians, who lack training, education, and experience in management theories and practices. As one participant in this study commented, " My immediate supervisor needs

extensive training on how to be an appropriate and effective manager - especially in the areas of 1) communication, 2) support, and 3) trust/safety." Another participant commented, " Most supervisors do not know how to supervise. They are all ex-caseworkers and do not have the skills to run our programs effectively, especially at the start of managed care." Although some training in this area should clearly fall on the educational training institutions, in reality, supervision and management skills may require training which occurs after the student has been functioning as a professional for some time. Fledgling professionals are often more concerned with building their competence and skills (Cherniss, 1995), and may not be able to integrate the skills necessary to become an effective supervisor and manager until they have mastered the earlier stage of professional development. Thus the ultimate responsibility for training professionals in how to be capable supervisors may rest with the agency who employs and promotes the professional (Freedman, 1997).

Obviously, the relationships investigated in this study do not account for all the variance in the phenomena of work-related burnout. The relationship between leadership practices and burnout is but one piece of the puzzle which represents the interface between the practitioner, their clients, and the organization. Work environment, physical working conditions, workloads, organizational problems, lack of resources, and organizational climate are just a few of the external variables that can impact the amount of stress any given individual practitioner will experience. Personality traits, coping resources, perceptions and appraisals, gender, and home life are a few of the internal variables that can explain or mediate the effects of stress (Guglielmi & Tatrow, 1998). Multimethod measurement strategies which take into consideration the multiple aspects of burnout and its theoretical causes within the same research design research would be very useful in illuminating and untangling the complexities of burnout in mental health professionals. However, as has been noted elsewhere (see Leiter, 1991), mental health systems have been reluctant to participate in the type of intense inspection that multivariate strategies would

demand. If research is to expand in this direction, investigators will need to invest time to develop the necessary relationships with the mental health organizations, which includes the administration, the practitioners, and the employee's unions.

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Appendix

Clinical Supervisor Rating Scale

Please read the following statements carefully and decide the extent to which you agree or disagree with the statements.

0	1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

RATING

1. _____ My supervisor makes time for supervision or consultation whenever I need it.

2. _____ My supervisor makes efforts to create a supervision atmosphere of safety, support, and trust.

3. _____ I feel comfortable to take risks in supervision without danger of an excessively judgmental response from my supervisor.

4. _____ My supervisor uses his/her power and authority responsibly in supervision.

5. _____ My supervisor provides supportive, empathic, nonjudgemental supervision.

6. _____ My supervisor and I share a mutual understanding and agreement in regards to our supervisory contract.

7. _____ Supervision, as conducted by my supervisor, parallels that of the therapeutic relationship such that I feel empowered following my supervision hour.

Table 1. Descriptive statistics for variables.

Variable	Mean	SD	Actual Min	Actual Max	Possible Min	Possible Max
Leadership Practices Inventory						
Encouraging the Heart	39.3	15.3	6.	60.	6.	60.
Enabling Others to Act	44.4	12.7	8.	60.	6.	60.
Inspiring a Shared Vision	36.0	13.2	7.	60.	6.	60.
Challenging the Process	38.1	14.0	6.	60.	6.	60.
Modeling the Way	42.0	13.4	6.	60.	6.	60.
Maslach Burnout Inventory						
Personal Accomplishment	40.3	5.5	25.	48.	0.	48.
Emotional Exhaustion	23.2	10.3	4.	48.	0.	54.
Depersonalization	7.1	5.1	0.	25.	0.	30.
Clinical Supervisor Rating Scale	24.8	9.1	0.	35.	0.	35.

Table 2. Distribution of scores on the Leadership Practices Inventory scales (in percentages).

Composite Score: / Typical Response per Item:	6-12 1's & 2's	13-24 3's & 4's	25-36 5's & 6's	37-48 7's & 8's	49-60 9's & 10's
Leadership Practices Inventory Scales					
Encouraging the Heart	9	8	20	31	32
Enabling Others to Act	3	9	8	34	46
Inspiring a Shared Vision	6	13	26	35	20
Challenging the Process	6	13	18	37	26
Modeling the Way	5	9	12	35	39

Note. Each composite score is based on the combined responses to six items for which respondents are asked to, "rate your supervisor in terms of how frequently he or she [typically] engages in the practice described." The following scale is indicated:

1=	Almost Never	2=	Rarely
3=	Seldom	4=	Once in a While
5=	Occasionally	6=	Sometimes
7=	Fairly Often	8=	Usually
9=	Very Frequently	10=	Almost Always

Table 3. Distribution of scores on the Maslach Burnout Inventory scales (in percentages.)

Cutpoints for Mental Health Workers[1] Composite Score:	Low	Moderate	High
Personal Accomplishment.....	34 or more	29-33	0-28
Emotional Exhaustion.....	0-13	14-20	21 or more
Depersonalization.....	0-4	5-7	8 or more
Maslach Burnout Inventory scales			
Personal Accomplishment[2]	86	12	2
Emotional Exhaustion	17	29	54
Depersonalization	34	28	38

Note: (1) The cut points for categorizing level of burnout are taken from the Administration Manual for the Mental Health Occupational Subgroup. (2) The Personal Accomplishment scale scores are inversely related to burnout level.

Table 4. Distribution of scores on the Clinical Supervisor Rating Scale (in percentages).

Composite Score: Typical Response per Item:	0-7 0's & 1's	8-14 2's	15-21 3s	22-28 4's	29-35 5's
Clinical Supervisor Rating Scale	8	7	11	35	39

Note. The composite score is based on the combined responses to seven items for which respondents are asked to indicate the extent to which they agree or disagree with the statements." The following scale is indicated:

0= Strongly Disagree 1= Disagree 2= Somewhat Disagree
3= Somewhat Agree 4= Agree 5= Strongly Agree

Table 5. Correlations between mental health providers' expression of burnout and the leadership and supervisory practices they experience.

	Maslach Burnout Inventory Scale		
	Personal Accomp-lishment	Emotional Exhaustion	Depersonali-zation
Leadership Practices Inventory			
Encouraging the Heart	-.01	-.23*	-.18
Enabling Others to Act	.05	-.28*	-.22*
Inspiring a Shared Vision	.14	-.23*	-.23*
Challenging the Process	.07	-.26*	-.23*
Modeling the Way	.05	-.24*	-.23*
Clinical Supervisor Rating Scale	.12	-.25	-.22*

*$p<.01$